

A Commanders' Guide for Conducting Integration Operations
in the San Antonio Military Health System

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| 14. ABSTRACT Commanders preparing for integration operations in the San Antonio Military Health System (SA-MHS) should be cognizant of three important considerations: the majority of all mergers, acquisitions, collaborations, and consolidations fail to achieve pre-integration goals; the military is not well-trained in conducting these type of operations; and the track record for collaborations and consolidations in the SA-MHS is not good. Despite these daunting caveats, conducting successful integration operations is not mission impossible. A dedicated, well-educated staff, a relatively secure beneficiary population, and currently, significant protection from competitors provide considerable organizational strengths that can be employed to overcome the numerous obstacles for successful integration operations. The most prevalent factor in Integration Operations that has yielded less-than-optimum operational efficiencies is the failure of organizations to create and implement an effective integration plan. Organizations that are able to clearly articulate achievable goals, develop a comprehensive plan to conduct integrations, and flexibly execute both current operations and integration operations generally achieve success. This study was undertaken in order to produce a commander's guide that may enhance the propensity for success in the event of any future integration operations in the SA-MHS. | | | | | |
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Conditions which prompted the study

Wilford Hall Air Force Medical Center (WHMC), Lackland Air Force Base, and Brooke Army Medical Center (BAMC), Fort Sam Houston, are located in San Antonio, Texas and exist as two of the Department of Defense's largest military treatment facilities. WHMC is the largest medical center in the Air Force staffed by 4,689 active-duty service members and civilians that work in facilities comprising 3.2 million square feet. Additional medical assets for Air Force personnel in San Antonio include separate clinics at Randolph, Brooks, and Kelly Air Force Bases. BAMC boasts the newest facility in the Department of Defense. The facility provides 1.5 million square feet of working space for 2,542 staff members consisting of active-duty service personnel and civilians. Both medical centers provide a comprehensive array of medical services, teaching programs, and research facilities. The combined Defense Health Program expenditures for the two medical centers currently exceed \$600 million annually. (Region 6 TriCare Office, 1998).

Over the past three years, WHMC and BAMC have taken actions to integrate Graduate Medical Education (GME) programs while investigating ways to conduct more efficient resource sharing within the federal healthcare sector in San Antonio. The impetus for finding ways to better utilize resources is directly attributed to a general decline in the relative budget allocations to the facilities and a series of personnel reductions that BAMC has recently experienced and that WHMC is preparing to undergo in the next two years.

On August 18, 1998, the Assistant Secretary of Defense published the latest official policy decisions regarding the Department of Defense budget programs for fiscal years 2000-2005 via a Program Decision Memorandum (PDM). The purpose of this memorandum was to provide guidance for future budget estimate submissions and to affect change in Department of

Defense operating activities in order to match projected congressional funding levels. One significant policy decision found in the PDM directs consolidation of “Wilford Hall Air Force Medical Center (WHMC) and Brooke Army Medical Center (BAMC) in San Antonio, Texas, considering all DoD medical facilities and managed care services contractor capabilities in the area.” (Office of the Secretary of Defense, 1998). Based on this directive, Major General P.K. Carlton, Commander, TriCare Region 6 and Wilford Hall Air Force Medical Center, and Brigadier General Harold L. Timboe, Commander, Great Plains Regional Medical Command and Brooke Army Medical Center, created an Integration Workgroup to study area consolidation scenarios and to propose courses of action for presentation to the service Surgeons General and the Assistant Secretary of Defense for Health Affairs.

The latest iteration of proposed consolidation follows an ill-fated attempt to create a joint medical structure in San Antonio during the late 1980’s with the establishment of the Joint Military Medical Command (JMMC). The JMMC was expected to consolidate Graduate Medical Education programs, save military construction program funds by eliminating the need to construct the New Brooke Army Medical Center, and to reduce duplicative services (Burke, 1990).

The idea of achieving cost-savings in the San Antonio military medical area pre-dates even the managed-care era actions of JMMC. By intending to “assure against overbuilding of facilities, to avoid overlapping and duplication of Federal medical services, and to ensure maximum utilization of the total Federal medical services”, President Eisenhower issued a consolidation directive in 1956 stating that the Air Force would be given the military medical responsibility for regional, specialized treatment services in San Antonio as that service possessed the preponderance of military personnel assets in the area. Brooke Army Hospital was

supposed to downsize to a basic station hospital and the makeshift wards in Beach Pavilion were to be reconverted to troop barracks (Executive Office of the President, 1956).

In both instances, these actions failed to achieve targeted outcomes. WHMC and BAMC continue to operate as service-autonomous medical centers. Contrary to the stated goals of JMMC, New BAMC was completed in 1995 and, despite President Eisenhower's best intentions for expanding barracks space at Fort Sam Houston, Beach Pavilion continued to exist as a patient care facility until the relocation of patient care activities to New BAMC in 1996.

These experiences mirror the reality that private industries have been facing for many years. In spite of the best intentions and compelling reasons for organizations to merge, collaborate, or consolidate, the majority of integration operations fail to meet expectations. The single most prevalent factor that has yielded less-than-optimum operational efficiencies is the failure of organizations to create and implement an effective integration plan. Organizations that are able to clearly articulate achievable goals, develop a comprehensive plan to conduct integrations, and flexibly execute both current operations and integration operations generally achieve success. This study was undertaken in order to produce a commanders' guide that may enhance the propensity for success in the event of any future integration operations in the San Antonio Military Health System (SA-MHS).

Introduction

Commanders preparing for integration operations in the SA-MHS should be cognizant of three important considerations: the majority of all mergers, acquisitions, collaborations, and consolidations fail to achieve pre-integration goals; the military is not well-trained in conducting these type of operations; and the track record for collaborations and consolidations in the SA-MHS is not good.

Studies conducted in the past twenty-five years consistently demonstrate that the majority of mergers, acquisitions, and consolidations fail to achieve targeted outcomes. The metrics for measuring success in these studies include cash-flow, revenues, profits, common stock price appreciation, and return on equity and are usually associated with “for-profit” commercial enterprises. Although these measures are not generally associated with success considerations in the military health system, the qualitative reasons for failure stated in the studies serve as valuable lessons for military planners: poor operating synergies, inadequate due diligence, poor planning, poor communication, slow integration, and lack of vision. (Lajoux, 1998).

The stated purpose of the United States military is “to protect and defend the Constitution of the United States against all enemies” and the historical practical application of this mission is to deliver overwhelming military force upon our enemies in order to destroy their capacity to threaten our national security. It should be expected that the resounding and recurring organizational focus of the military has been to concentrate on training to attain the means to achieve this end. All other actions are secondary in importance.

Although the military has often been required to perform non-doctrinal missions ranging from civil works projects during the Depression to modern-day “peace-keeping,” success in these endeavors has been difficult to achieve. Similarly, conducting “the business” of the military is an idea that is relatively new to the armed forces. Although fiscal prudence and avoiding “fraud, waste, and abuse” are intuitive operational touchstones for most service members, the preponderance of military actions have been “requirements based.” Most units or service members know what resources are required in order to meet mission and the expectation is that “higher headquarters” will insure that these resources are provided with relatively little regard to cost. Recently, however, budget decrements, base realignment and closures, and unit

deactivations\inactivations have suddenly caused a change in the equation: “higher headquarters” still provides missions, however, subordinate organizations are expected to fulfill missions with whatever resources are available. The results of these actions have caused considerable stress to units and service members that has resulted in a number of negative consequences ranging from retention problems to dangerous working conditions. The underlying point is that the military is often assigned missions or assumes roles where it is not well suited for success. Therefore, given the current personnel and organizations, and despite the recent increase in opportunities for Training with Industry and post-baccalaureate education, meaningful increases in operational efficiencies through a merger or consolidation of healthcare resources in the SA-MHS will be especially difficult to achieve.

One final consideration is that the record for collaborative or consolidation efforts between the military treatment facilities in San Antonio highlights a series of failed or irrelevant initiatives. The consolidation efforts of President Eisenhower and the JMMC initiative ultimately failed despite good, fundamental rationale and some operational successes. The post-JMMC San Antonio Health Care Coordinating Council (SA-HCCC) exists only “on-paper” since its creation and has only recently received some consideration due to the PDM proposals and calls for “resource-sharing” among the federal healthcare agencies in the area. Additionally, the four separate Air Force medical facilities have just begun to operate tentatively in a manner resembling a comprehensive health system. Finally, the joint GME program is demonstrating signs of distress. One leader noted, “The joint GME program is beginning to show serious cracks. It was a program that was mandated from the top...showed no real benefits to the people at the “worker-level”...provided no cost savings...and now the people that mandated it are

gone.” (Baskin, 1999). Obviously, any future integration operations in the SA-MHS must overcome this legacy of failure.

Despite these daunting caveats, conducting successful integration operations in the SA-MHS is not mission impossible. A dedicated, well-educated staff, a relatively secure beneficiary population, and currently, significant protection from competitors provide considerable organizational strengths that can be employed to overcome the numerous obstacles for successful integration operations. The key to achieving success will be found with simplicity and adhering to some basic principles coined “The Three C’s of Integration: Clarity, Conflict Resolution, and Consensus Building.” (Cliff, 1999). The following chapters outline basic themes for conducting successful integration operations in sequenced phases starting with “Preparation” and concluding with “Completing the Integration.” The presentation format of each chapter is to introduce an integration theme with proposals based on real world lessons-learned or situational analysis that will facilitate successful completion of the designated phase. In many cases, specific suggestions will be presented, however, when integration operations are initiated, the scope of the integration, situational considerations, or simply commander’s discretion will certainly preclude the implementation of some specific recommendations.

Preparation

Albert Viscio, vice-president of Booz-Allen and Hamilton, an influential consulting firm, specializes in the development of post-merger integration plans. His recurring theme for integration preparation includes the basic concepts of vision, architecture, and leadership. The questions that he asks his clients include “What will the future organization look like?”, “How do the organizations fit?”, “Who is going to lead the organization?”, “How is this going to benefit the organization?”, and “Will the key stakeholders understand?”. (Cliff, 1999). This advice

supports research indicating that integration failures are rooted in the process inception. Given this advice, Commanders developing a plan for integration should insure that the initial proposal demonstrates clear intent and motivations, achievable goals and objectives, and is unambiguous in regards to command and funding.

A recurring cry from the rank and file of many merging organizations is “If they would have told us from the start the reasons for the merger, it would have been a whole lot easier.” This sentiment has been echoed during integration operations by other stakeholders including shareholders, customers, and business partners. The consequences of their angst include resistance, sabotage, high employee-turnover, and enduring resentment. It is essential that the stakeholders in the SA-MHS completely understand the basic rationale and consequences of integration operations. An important key for integration success is to achieve at least compliance and ideally commitment from the people who will ultimately determine the success or failure of the integration.

The message to achieve this goal should include as many realistic specifics as possible and should address the major concerns of stakeholders. In effect, commanders will be perpetually “selling” the idea of integration to employees and beneficiaries. The “selling points” that must be addressed include “Why is the integration being done?”; “Who is going to lose their job?”; and “How will the integration affect the delivery and availability of healthcare?” The message should be so simple that the most junior employee or any beneficiary could explain the basic concept.

It is important to begin any endeavor with at least some certainty of success. The latest steps to undertake integration in the SA-MHS clearly exhibit lessons to be learned by Commanders. As the goals of the 1998 PDM were released in Washington, D.C., the plan to

consolidate the military healthcare facilities in San Antonio were met with resounding opposition from the area congressional leaders. Representative Ciro Rodriguez stated that the plan was “dead on arrival.” (Christenson, 1998). In another example of conflicting goals and reality, the Army Surgeon General stated that “there are currently no methodologies to measure the benefits of a potential consolidation” (Blanck, 1998), however, military planners had staked a cost-saving target of \$150 million over five-years to the consolidation initiatives. The civilian experience with integration goals has shown that unrealistic goals are rarely achieved and the recent military health system actions do not bode well for potential successes in the SA-MHS. Therefore, diligent consideration for political, financial, accreditation, and operational factors should be evaluated before beginning any integration operations. Furthermore, to support the issue of clarity, the goals and objectives identified during the integration preparation phase should be realistic and easily understood by the stakeholders.

The final component of the preparation phase is to eliminate issues of ambiguity in the integration process. Mr. Mike Berman, director of Public Relations at Compaq Computer and a key member of the integration operations being conducted during Compaq’s acquisition of Digital Computer, provided valuable insight into the need to eliminate potentially disruptive issues. In order to diffuse inevitable “turf battles”, questions of authority, and leadership roles, Compaq addressed the issues of leadership and responsibility at the very beginning of the integration process. Compaq quickly established a combined management leadership hierarchy, set the tone for integration operations, and actively marketed the new leadership arrangement to stakeholders. Additionally, to achieve elements of consensus building, the company assigned manager and director positions within the new company based on the individual competencies and skills of the combined pool of personnel.

An important lesson-learned by Compaq and other companies that have conducted integration operations, is that merging organizations rarely succeed with “management by equals.” The failure to clearly identify clear responsibility chains ultimately becomes counter-productive to efficient operations. (Mirvis and Marks, 1992). It is especially important for the SA-MHS to eliminate the many potentially ambiguous aspects of integration because the idea of an established chain of command is inherent to the basic values of the armed forces. Currently, the military treatment facilities basically exist as autonomous commands, however, responsibility to “higher headquarter” involves a myriad of combinations including installation commanders, intermediate military health system commands, high-ranking local line commanders, the individual service Surgeons General, and the Tricare Management Activity (TMA)\Lead Agent. Furthermore, each facility is separately funded in a manner that allows facility commanders considerable latitude in how resources are employed. Other operational considerations that will require clarification include regulations, personnel evaluation reports, awards system, civilian collective bargaining units, and service-specific military readiness training. Finally, the very basic military elements of rank, position, and authority are currently being strained daily in the joint BAMC-WHMC GME programs, often with considerable conflict due to conflicting service allegiances.

In order to reduce the potential efficiency decrements to integration and post-integration operations, commanders must clearly establish and enforce chains of command, roles and responsibilities, and budget funding considerations in a manner that is realistic and supportive of the underlying goals of the integration. The means to achieving this end will likely be found by assigning individual roles and responsibilities commensurate with skills and competencies while unifying command and resource authority in a single chain of responsibility.

The bottom-line for the Preparation phase of integration is as follows: Commanders must clearly articulate a compelling reason for integration operations to all stakeholders. Furthermore, the reason for the integration must be accompanied by substantive, achievable goals, an easily understood, meaningful model depicting the future organization, and a unified chain of responsibility and resourcing that will facilitate efficient operations.

Managing the Integration

The method for managing integration operations is perhaps as the most important aspect of the process. In fact, one Price-Waterhouse merger consultant noted that “merging companies which do not implement a well-defined post-merger integration plan will be doomed to failure.” (Woo, 1997). Achieving the integration concepts of consensus building and conflict resolution are important elements in this phase of integration operations because organizations generally must “join-together” while conducting semi-independent current operations. Integration operations in the SA-MHS will likely be conducted while all participating organizations continue to perform healthcare delivery, GME, and readiness training. The key to success in this phase of integration is to create a minimally disruptive parallel mechanism with ad hoc organizations to complete integration operations while current operations continue. The components of the mechanism include a Script, an Integration Board, and Integration Teams.

Alexandra Lajoux, a merger integration consultant, describes the Script for conducting integration operations as follows: “outlining exactly when and how resources, assets, processes, and commitments...will be combined in order to achieve the strategic goals of the newly combined organization.” (Lajoux, 1998). Essentially, the Script should be a time-phased plan to bring the integrated components of the military healthcare resources together. The time duration of the integration Script will be directly dependent upon the scope of the operation,

however, based upon the experience of civilian organizations, at least one year and no more than two years should be dedicated to completing the integration. Essential elements of the integration Script are recurring weekly, bi-weekly, and quarterly progress reports to key leaders, ample planning, adjustment, and execution time for service and branch-level organizations, and reports to stakeholders.

The second element for Managing the Integration is the Integration Board. The role of the Integration Board should be to monitor the progress of integration operations, administer conflict resolution for the inevitable issues of disagreement, and to report integration status to stakeholders. Members of the SA-MHS Integration Board should include facility commanders, senior individual multi-disciplinary representatives from the facilities, and a representative from stakeholder organizations such as installations, service medical commands, and TMA\Lead Agent.

A final member of the Integration Board may be a consultant specializing in integration operations. This consultant could be a military service member assigned from within the military services or a hired contractor. Criteria for evaluating the need for a hired consultant should include cost, experience, quality of support staff, and schedule availability. Commanders should strongly consider adding this member to the Integration Board if the integration experience, expertise, or objectivity of the other board members is questionable. (Lajoux, 1998).

The Integration Board should meet no less than monthly to receive progress reports, assess integration status, and resolve issues of conflict; however, the Board should be available to meet within a reasonable amount of time in the event of emergencies. The Integration Board, chaired by the senior officer, should establish appropriate rules of order in regard to conducting

meetings, voting, and committees. Additionally, the Board should establish a progress-reporting format and criteria for presenting issues of conflict.

The experience of Compaq Computer\Digital Computer coupled with the integration management guidance from Mirvis, Marks, and Lajoux indicate that the establishment of the Integration Board is essential to guiding the integration while current operations continue. It is important to recognize that the members of the Integration Board and virtually all personnel will be “dual-hatted” during the integration and the board provides leadership and oversight for the ad hoc “dual-hatted” organization.

The final element for Managing the Integration is the Integration Team. The Integration Team is the lowest level organization in the integration process and is effectively where change occurs. The mission of Integration Teams is to integrate the operations of a single product line, branch, or service within time-lines and parameters established by the Integration Board. Membership on the committee should include key leadership from each facility within the product line, service, or branch.

Mr. Bill Rasco, President of the Greater San Antonio Hospital Council and former JMMC Chief of Staff, identified Integration Teams as one of the most important sources of progress during the JMMC period and an essential element to any integration. Besides carrying out the task of integrating the respective organizations, Mr. Rasco observed that many of the efficiencies or great ideas during the integration were gained through cross-service interaction between members of the teams. (Rasco, 1998).

During integration operations, intermediate Integration Teams should be created to assist the Integration Board in the oversight and administration of the integration. For instance, a Logistics Integration Team would provide guidance, oversight, and conflict resolution to a series

of individual product line logistic Integration Teams such as maintenance, laundry, or property management. Additionally, a schedule of Integration Teams with points of contact and methods for communication should be created in order to facilitate cross-consultation between teams for specific information.

The bottom line for Managing the Integration is that Commanders must manage the integration as though it were single mission with a new organization while continuing to fulfill ongoing healthcare, GME, and readiness missions. Success will be achieved by creating a detailed time-phased, event-driven script that is managed by the Integration Board and executed by the Integration Teams.

Maintaining Effective Communication

A history of communication processes during integration operations could be summed as follows: rumors, half-truths, complaints, and silence. Of all the reasons that integration operations fail to achieve targeted outcomes, lack of effective communication is included as a major contributing factor in most every case (Marks and Mirvis, 1998). In order to achieve Effective Communication in integration operations, Commanders must embrace each of the “Three C’s of Integration: Clarity, Conflict Resolution, and Consensus Building” while focusing on three aspects of communication: Message, Audience, and Medium.

The simple truth concerning the Message aspect of Maintaining Effective Communication is that stakeholders simply want to hear the truth in a timely manner. Furthermore, stakeholders need to have the Message repeated and reinforced throughout the integration process. Integration operation literature is filled with instances where leaders failed to achieve effective communications with stakeholders by providing untimely reports, inaccurate information, or no information. Common excuses cited by managers for failing to effectively

deliver the Message include “There’s nothing to say,” “No news is good news,” “Let the public affairs people do it,” and “We’ve already told them that.” (Mirvis and Marks, 1998). Often the immediate result from lapses in effective communications is rumors, complaints, and less efficient operations as stakeholders struggle to understand. Commanders should ensure that the content of integration Messages incorporate information in a manner that will enhance integration clarity while simultaneously fostering conflict resolution and consensus building.

The potential Audiences in the SA-MHS will include all stakeholders. It is important, however, to remember that different stakeholders frequently have unique criteria for successful communication, therefore, it is important that Commanders fashion Messages in a manner that is congruent with the information needs of specific stakeholders. Additionally, separate groups of stakeholders will react differently to the absence of information or the content of the Message.

For instance, the collective bargaining units representing the civil service employees will be keenly interested in employment status and will vigilantly monitor information for specific references to job cutbacks, hiring freezes, potential hires, and outsourcing. Depending on the content or volume of information presented during integration operations, this group could react in a wide range of means including industrial sabotage to renewed working enthusiasm. Similarly, the beneficiary population will want to know how integration operations will change the healthcare delivery experience. The range of reactive options available to this stakeholder group could include decreased utilization, complaints, or complete support of the proposed initiatives. (Marks and Mirvis, 1998).

Although assessing the information needs for particular groups of stakeholders is generally intuitive, Commanders should be constantly sensitive to the information needs of

specific groups and fully aware of the impact that the failure to fulfill those specific needs may bring to the integration process.

The final component for Maintaining Effective Communication is the Medium. Just as different stakeholders require specific information and react differently to the absence of information or content of delivered information, the Medium for specific types of Message and Audience groups is an important consideration. While conducting integration operations, BJC Health System, a large metropolitan healthcare system based in St. Louis, developed a special model to predetermine the method of communication for specific stakeholder groups. For instance, BJC chose to use simple advertising to communicate integration information to the general public and commercial customers because the integration leaders were advised that television, radio, and print advertisements achieved the most favorable impact on these groups. (Lerner, 1997).

Commanders should be aware of the wide-range of information Mediums available and how these Mediums affect overall integration Clarity, Conflict Resolution, and Consensus Building. The preferred option for effective communication is face-to-face interaction with individuals or small groups and this Medium should be employed as regularly as Commanders can afford. However, large group sessions, video teleconferences, dial-up information hot-lines, local area network integration bulletin boards, letters, local news interviews, advertisements, and decentralized first-line leader briefings are all viable Medium options for different Messages and Audiences.

The bottom line for Maintaining Effective Communication is that Commanders should perpetually consider the importance of the individual elements of communication, potential

reactions by stakeholders to the communications process, and how communications impact the overall integration operations.

Overcoming Differences

One of the basic assumptions of any type of integration operation is that differences will exist between the separate parties. It is virtually inevitable that integration operations will be conducted with some degree of different organizational cultures, values, priorities, facilities, locations, and operating procedures. Not surprisingly, a significant goal of the pre-integration process is to match potential partners with similar organizations that are likely to be most compatible. The potential integration of similar organizations in the SA-MHS reveal basic differences such as Army and Air Force, Policies and Procedures, and Facilities that must be overcome in order to increase the likelihood for successful integration operations.

The late Dr. Carl Builder, a RAND Corporation researcher, conducted an intriguing study of the different ways that the military services conduct policy decisions, prioritize actions, and conduct operations in addition to how the services view themselves and other branches. In his study, Dr. Builder depicted the Army as “the country’s loyal, obedient servant” that is ready at a moment’s notice to take charge of the country’s defense without little regard to potential perils. The Army is confident that the collective heroism, duty, and honor of its soldiers will prevail in any situation. The Air Force, on the other hand, is characterized as an organization that is fixated on “its continuing existence-its justification as an independent institution.” Dr. Builder asserts that the Air Force’s driving goal is to procure and use the most advanced aerial equipment and weaponry to singularly overcome any force that flies, walks, floats, or rolls so that it will remain an autonomous organization apart from the Army or Navy. Furthermore, the threat of being outnumbered is not particularly worrisome to the Air Force, however to be “out-

maneuvered” or to encounter superior technology or equipment is considered an unforgivable sin. Consequently, the Air Force culture seems to encourage institutional traits of superiority and individuality. (Builder, 1989).

Current SA-MHS operations and interactions between personnel assigned at the different facilities appear to partially confirm Dr. Builders’ positions while presenting possible problems for future integration operations. In many situations, Air Force personnel seem particularly concerned and defensive when there is an appearance that the Army is “trying to take things over.” The Air Force is not unique, however, in being sensitive to the perceived actions, beliefs, or agendas of other services. Several Army healthcare providers at BAMC openly complain that the Air Force medical community at WHMC perceives Army Medicine as crude and outdated.

The possible consequences of these circumstances could create a myriad of potential integration problems. Withholding data, lack of participation, sabotage, and staff resignations are all possible detractors resulting from unproductive stereotypes. Conflict resolution in these situations will likely be found through visionary leadership and education. Commanders must overcome the prejudices, misconceptions, and negative attitudes toward other services by appealing to common goals and objectives. Additionally, an education process must be incorporated into the integration that will decrease the unknown elements of each service. Other means for overcoming cultural differences include combined group events such as organization picnics, small group retreats, intramural teams, military ceremonies, and social events. Finally, as the services begin to share operational experiences, differences will begin to blur, but only after considerable time and events have transpired.

The military is infamous for institutionally unique policies, procedures, and methods. Fortunately, the individual services derive these operational support structures from common federal laws, guidelines, and regulations, thus, although the specifics of some policies may vary, the basic underlying theme is the same.

When BJC Health System conducted a review and reestablishment of the separate Barnes, Jewish, and Christian Hospitals' policies, procedures, and methods, two themes prevailed in determining the combined administrative structure: "Sooner is Better than Better Later" and "Best Practice or Common Practice." BJC Health System leaders determined that it was vitally important to establish a viable administrative structure early in the integration process in order to facilitate the wide range of actions to be completed. The means for achieving the aggregate system was to evaluate the separate existing systems according to "Best Practice or Common Practice." In the event that an obviously "Best Practice" existed among the previously separate organizations, then it was adopted by consensus. If no clear "Best Practice" could be determined, then a "Common Practice" was adopted that attempted to take the best parts from the separate sources. (Lerner, 1997).

Commanders directing integration operations should follow the example provided by BJC Health System. In many cases, regulations and policies will be mirrored in the separate organizations, however in the event that some methods do not match, then a common means for operating must be established in the "Best Practice-Common Practice" format. As the combined policies, regulations, and methods are adopted, an education process will need to be instituted to reinforce the new policies. For instance, the concept of personnel evaluation reports are inherently the same in the Air Force and Army, however the actual forms and some counseling criteria slightly differ. In this case, combined personnel already understand the process, but will

need to be educated on the specific aspects pertinent to individuals formerly assigned to the other system.

Hospital organizations undergoing integration operations routinely encounter some degree of conflict with facilities issues. Since the concept of a hospital was created, the actual facility became the central aspect of the employment, treatment, education, and research experience for most people. People affiliate their experiences with a building or structure that embodies the combination of all interactions. When a significant change such as an integration occurs, any real or perceived changes in the facility arrangement affects stakeholders. An example of this change is found in the SA-MHS as Brooke Army Medical Center moved from treatment facilities on the main post of Fort Sam Houston to new facilities on the peripheral grounds of post. The reaction of stakeholders ranged from nostalgic regret for the move to bolstered morale. One measurable reaction has been an increase in patient satisfaction for which the new facilities are partially attributable. A Commanders' strategy for overcoming any potentially negative reactions to facilities issues should be rooted in educating stakeholders about the reasons for facilities changes. Additionally, efforts to maintain or enhance the facility experience for stakeholders should be incorporated into integration processes.

The bottom line for Overcoming Differences is that these elements can significantly hinder integration operations, however, Commanders can overcome most differences with timely, thorough education, increased common experiences, and the passage of time.

Completing the Integration

The final theme for conducting integration operations is Completing the Integration. In order to effectively complete this phase of the integration, Commanders must incorporate some

elements of previously discussed integration themes into a relatively simple examination of metrics, time, and environment in the post-integration organization.

The concept of measuring performance in the military is based on organizational values of accountability and the appropriate allocation of resources. The military services use measurements such as personnel performance reports, unit status reporting, and review and analysis to track different aspects of operational performance. The integration process should not be any different. Integration experts encourage implementing integration metrics in order to track progress, make adjustments, and to insure two-way information flows. The key consideration for establishing integration metrics is that the measures should reflect the progress toward achieving the original goals of the integration. Furthermore, metrics should be selected that require accessible, reliable, and relevant data. (Marks and Mirvis, 1998). Since the 1998 PDM initiatives established consolidations as a means to achieving lower military healthcare expenditures, Commanders conducting integration operations could measure the success or failure of the integration based on the total funds expended for operations.

Although the formal integration operation for organizations generally requires no more than twenty-four months and generally last twelve months, a recurring lesson in integration literature is that the new organization will continue to evolve for several years. It is important that Commanders and senior policy makers realize that this phenomena exists and that military assignment policies could exacerbate this problem while extending the final integration timeline. Since military personnel generally rotate assignments relatively frequently, leaders at all levels rarely are able to observe and perpetuate meaningful change in organizations. The integration of military healthcare is a significant organizational change that requires the focused

attention of dedicated leaders. A course of action that Commanders could take is to request special stabilization assignments to keep key and essential military leaders in positions longer.

Finally, it is important to realize that things change. The military and the healthcare environment are constantly shifting as political and economic forces affect the reality of present operations and forecasts for the future. Indeed, prior to the release of the fiscal year 1999 budget, senior military healthcare leaders were desperately trying to determine how to take significant budget cuts in healthcare facilities, but congressional interdiction caused an increase of funds available and a potential crises was averted. Because of the military's subordinate role to political powers, Commanders should be constantly prepared to adjust integration operations to accommodate actions or policy changes for which they exert little or no control.

The bottom line for Completing the Integration is as follows: Commanders should measure integration progress with metrics corresponding to the original goals of the endeavor while realizing that meaningful change takes time and circumstances are likely to change.

Conclusion

Machiavelli counseled that "There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things." This time-tested advice in addition to the original three caveats for conducting integration operations in the SA-MHS should give Commanders reason to pause before beginning any form of integration. However, the reality of our environment dictates that action must be taken to conserve our resources and to prepare for a future filled with fiscal uncertainty. The military health system holds substantial numbers of healthcare providers and resources that are underutilized or not employed in the direct delivery of care. The proportion of the federal budget dedicated to the military and the Defense Health Program has steadily decreased in recent

years. Finally, despite recent and projected federal budget surpluses, a looming Medicare and Social Security funding crises could significantly constrain the availability of discretionary federal funds for the next three decades.

Service integration through consolidation, merger, partnering, or a number of similar methods serves as a legitimate adaptive strategy for Commanders and policy makers to pursue in order to conserve resources while continuing to complete readiness and healthcare missions. Therefore, it is likely that these type of operations will become more prevalent in the coming years.

The concepts and proposals presented in this guide represent simple, bottom-line analysis for a complex process. All of the individual themes of integration operations can be further researched and extrapolated depending upon the needs of the individual or group conducting the operations. For instance, leaders of Integration Teams may benefit from refresher training on conducting efficient committee operations or small-unit leadership. Additionally, the reference list to this guide provides a number of textbooks and journal articles that focus on specific aspects of integration. Finally, this guide includes an appendix section filled with pertinent charts, guidelines, and models associated with integration operations.

Commanders that choose to pursue this endeavor or are assigned to lead integration operations should remember and employ the “Three C’s of Integration: Clarity, Conflict Resolution, and Consensus Building” throughout each phase of integration operations. Perhaps just as importantly, leaders may be inspired by President Abraham Lincoln’s message as he exhorted the nation to change for the better: “The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. As our case is new, so we must think anew and act anew.”

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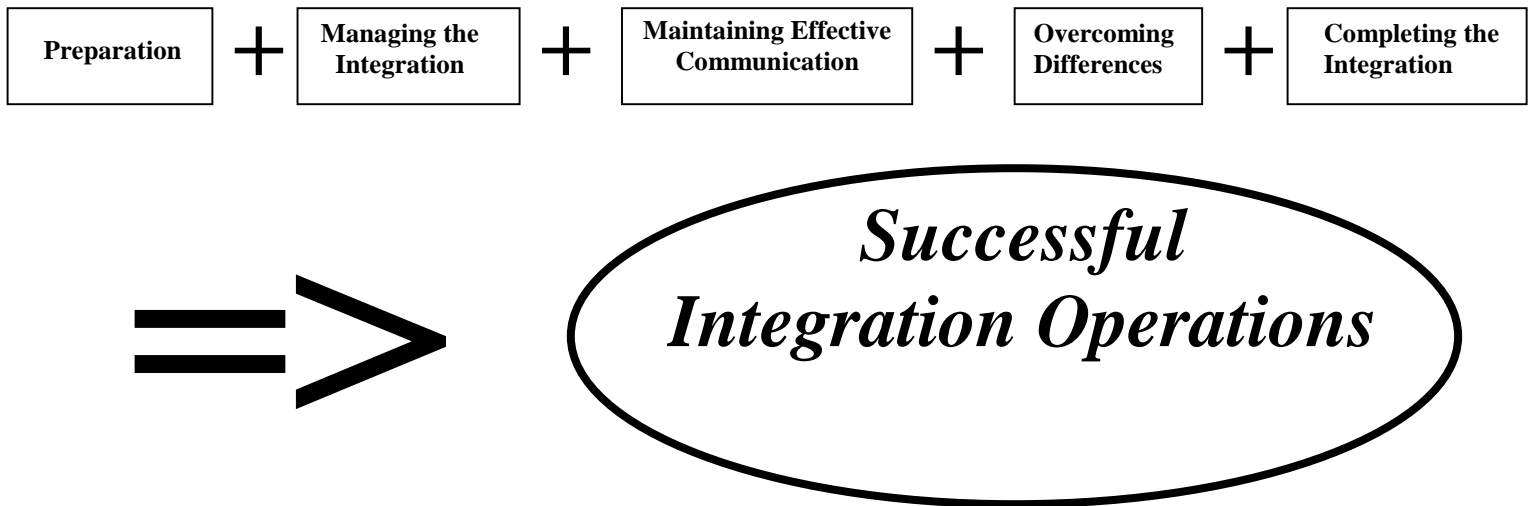
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Appendices

Commanders' Quick Reference Chart for Conducting Integration Operations



| Concept | Critical Components | Application |
|-------------------------------------|---|---|
| Preparation | Compelling Reasons Realistic Goals Elimination of Ambiguity | “Sell” Integration to Stakeholders Thoroughly assess risks\obstacles Establish one chain of command |
| Managing the Integration | Script Integration Board Integration Teams | Time-Phased Sequence of Events Lead and Manage Integration Implement Integration Plan |
| Maintaining Effective Communication | Message Audience Medium | Clear, Honest, and Timely Match Message with Stakeholder Consider Message and Audience |
| Overcoming Differences | Army\Air Force Policies\Procedures Facilities | Educate and Share Experiences Best Practice or Common Practice Minimize Impact on Stakeholders |
| Completing the Integration | Metrics Time Flexibility | Match Metrics to Goals Allow ample time for maturation Expect change due to politics |

“CEO’s Ten Commandments of Merger Leadership”

- | | |
|----------------------------|--|
| -Provide Direction | -Inform Your Staff |
| -Expect Change | -Get Your Staff on Board |
| -Be Positive | -Build Your Team |
| -Clarify and Manage Issues | -Let the Staff Manage Their Way Through It |
| -Inform Yourself | -Get on With It |

(Mirvis and Marks, 1992)

“12 Signs of the Merger Syndrome”

- | | |
|----------------------------|---|
| -Preoccupation | -Clash of Cultures |
| -Imagining the Worst | -We versus They |
| -Stress Reactions | -Superior versus Inferior |
| -Crises Management | -Attack and Defend |
| -Constricted Communication | -Win versus Lose |
| -Illusions of Control | -Decisions by Coercion, Horse Trading, or Default |

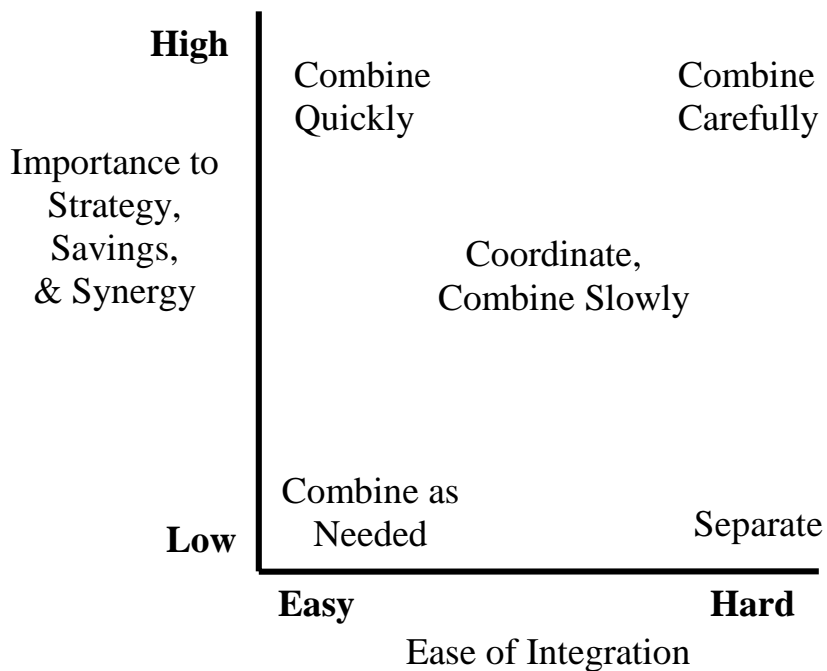
(Mirvis and Marks, 1992)

“Managing Merger Stress: Symptoms and Remedies”

| <u>Stress Symptoms</u> | <u>How to Respond</u> |
|---|---|
| Worry, Fear, Loss, Anxiety Anger, Withdrawal | Self-assessment and Counseling Sensitization Seminars and Realistic Previews |
| Uncertainty and Rumor-Mongering | Regular Communication or Merger “Hot Lines” |
| Loss of Control | Employee Involvement and Employee Assistance |
| Loss of Focus or Commitment | Performance Planning and Retention Programs |

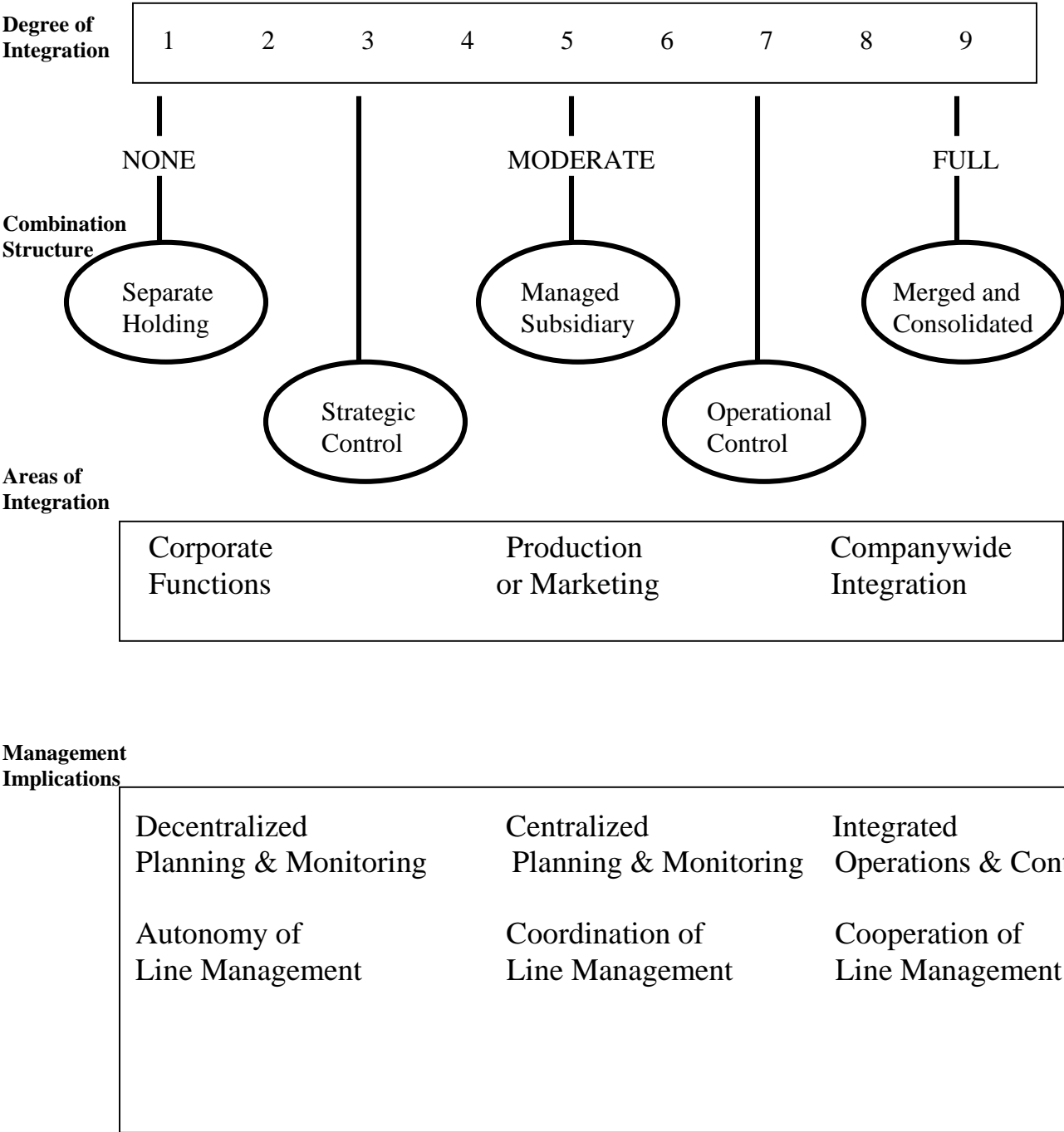
(Mirvis and Marks, 1992)

Determining Integration Pace Benefits versus Ease



(Mirvis and Marks, 1992)

Degree of Integration between Companies



(Mirvis and Marks, 1992)